MINUTES

Assessment Work Group Meeting #6
February 9, 2011 1:00-3:30 pm
Office of Community Provider Network of RI

Agencies/Organizations:			Present = X
Ray	Arsenault	Spurwink/RI	X
Sue	Babin	RIDD Council	
Melissa	Charpertier	Seven Hills/Homestead	X
Sheila	DiVincenzo	Cranston Arc	
Mitchell	Dondey	Trudeau Center	X
Anne	Doran	PAL	
Kathy	Ellis	Avatar	X
Pat	Fiske	Cove Center	X
Antonia	Greco	CPNRI	X
Lynne	Hadaway	Project Friends	
Lisa	Izzo	Spurwink RI	
Janet	Iovino	Sherlock Center	X
Tom	Kane	Cranston Arc	X
Chris	Kavanaugh	Re-Focus	
Donna	Martin	CPNRI	X
Doreen	McGonaghy	PAL	X
Kristen	Medeiros	Looking Upwards	X
Julie	Nernier	Re-Focus	
Judy	Niedbala	Perspectives	X
Stanley	Olsson	LIFE, Inc.	
Cathy	Procaccini	Fogerty Center	
Cheryl	Ring	Frank Olean Center	X
Claire	Rosenbaum	Sherlock Center	X
Mary	Wambach	Corliss Institute	X
Linda	Ward	Opportunities Unlimited	
Mary Ann	Wiedenhofer	LIFE, Inc.	
State Staff:			
Linda	Giguere	BHDDH	X
Joe	Gould	BHDDH	
Tom	Martin	BHDDH	
Charles	Williams	BHDDH	X
Consultants:			
Gretchen	Engquist	Burns & Associates	X
Jon	Fortune	HSRI	

Mark	Podrazik	Burns & Associates	X

Topics Covered:

1. Report from Work Group on the protocol for administering the SIS — Work Group
2. Using the SIS in allocating resources — G.Engquist
3. Review of Louisiana and North Carolina resource allocation models — G.Engquist
4. Plans for next meeting — Charles Williams

Report from Work Group on the protocol for administering the SIS

Donna Martin spoke for the subgroup. The subgroup recommended that BHDDH ensure that the protocol for administering the SIS as prescribed by AIDDD be followed. It was also emphasized that the administration of the SIS is predicated on the fact that the assessors will receive the full set of training as prescribed by AIDDD and not an abridged version of the training. In an earlier meeting of the Assessment Group, there was a consensus to provide training beyond the AAIDD requirements and this is still the intent. The group requested that the AAIDD protocol be posted to the web.

Using the SIS in allocating resources

Gretchen Engquist walked through a presentation that gave a general outline of how to use the SIS in allocating resources. At the outset, she emphasized that when thinking about how to apply this approach in RI, the process will be informed by how RI is different from some other states:

1. There is more variability in the individuals served than in other states since there are no institutions in RI and has a higher number of people per 100,000 population than the national average. In addition, based on the sample data with all caveats, the support needs of people served are about the same as the norm seen in other states, but both behavioral and medical scores area higher. These factors suggest that more SIS levels are needed.
2. However, the low number of total individuals served in the system may not allow for as many SIS levels as desired because the sample ("n") in each level may not be statistically valid.
3. Because there are no institutions, the resource needs in the upper SIS levels that are created may be higher than those found in other states.

Other highlights of the presentation:

1. In addition to statistical tests, the SIS levels need to pass a "face validity" (common sense) test.
2. It is also essential that there is a clinical validation completed to test each SIS level before they are implemented to ensure that the amount of dollars allocated are sufficient to meet an individual's needs.
3. The supplemental questions selected by the Work Group will be used in the statistical analysis to inform the SIS levels, but at this point we don't yet know how or if they will.

4. So far, every state that has implemented a resource allocation model using the SIS has had a fee-for-service payment system as the underpinnings of the resource allocation levels.
5. It is not expected that the resource allocations at a given SIS level will be different between individuals that select the agency model versus the self-directed model.
6. The development of resource allocation models is iterative—the first models developed will not be the last. States usually "tweak" the models after they have been in place for some time, for example when more SIS assessments are complete, when more claims data on expenditures and utilization is available, etc.
7. Ideas about how to transition to the resource allocation models still need to be discussed.
8. The SIS pilot was informative, but the results cannot be used in designing the new resource allocation models due to the fact that the training for assessors was insufficient and the assessments themselves were voluntary and thus not random. Charles Williams indicated that we should put the SIS pilot behind us and focus on the new SISs for future resource allocations.

Review of Louisiana and North Carolina resource allocation models

Gretchen Engquist also introduced two ways that states have implemented resource allocation models—one based on hours of resources (Louisiana) and one based on dollars (North Carolina). She showed descriptive matrices for each SIS level in the Louisiana model separated between those living at home and those living independently. In the North Carolina model, she explained how they decided which services were included in resource allocations and which were excluded.

Within this segment, questions arose about who would develop the "nitty gritty" elements in the descriptive matrices for Rhode Island's SIS levels. Gretchen indicated that this could be part of the clinical validation study, which needs to be done by clinicians in Rhode Island. Charles Williams indicated that clinical validation should involve clinicians that do not have a financial stake in the funding of a specific individual. Work Group members expressed concern that this could be interpreted as removing all clinicians in the state that currently know the BHDDH population since there are so few of them and they could all be considered to have a financial stake if they work for an agency. There was some confusion between the clinical validation and the exceptions process discussed below. The clinicians in the exceptions process must be independent. However, support coordinators are a key source of input into that process. For the clinical validation study, RI may want to have both state and private clinicians who may have agency affiliations. Work Group members indicated that the description matrices and clinical validation should be done by clinicians that know the RI industry well.

In the context of the descriptive matrices of each SIS level, another discussion arose about how the exceptions process ("Level 8" in the SIS model shown) would be articulated. Work Group members expressed concern that this process is very important and cannot wait until there is a sufficient number of SIS assessments completed before the discussion begins. The exceptions process discussion should start now, since there is not clear articulation of the process currently.

Plans for next meeting

Charles Williams indicated that the next meeting is scheduled for Wednesday, March 2, 1:00-3:30 at the CPN office. The topics to be discussed at this meeting include who will administer the SIS and the timeline to complete the SIS on the entire population. Charles did offer that the target for beginning SIS assessments is June 1, 2011 and July 1, 2011 at the latest. A discussion to review the support coordination function as distinct from the social workers' responsibilities is also planned.